DO NOT STAPLE IN BAR AREA

[redacted]

Washington State Department of Social & Health Services

MHCP MULTIPLE PREMIUM PAYMENT ADJUSTMENT

1. Please complete the entire form.
2. All information requested is necessary to process adjustment.
3. Enter data from MAA Remittance and Status Report.
4. **Use black ink.**

Mail completed form to:
DIVISION OF PROGRAM SUPPORT
NON-INSTITUTIONAL ADJUSTMENT UNIT
PO BOX 9245
OLYMPIA WA 98507-9245

DATE

PROVIDER NAME AND ADDRESS	PATIENT IDENTIFICATION				
	FI	MI	BIRTHDATE	LAST NAME	TB
PROVIDER NUMBER / PROVIDER TELEPHONE NUMBER	4. PATIENT NAME				

	a. Claim number to be adjusted	b. Dates of service	c. Amount
Claim 1		From: To:	$
Claim 2		From: To:	$
Claim 3		From: To:	$
Claim 4		From: To:	$
Claim 5		From: To:	$
Claim 6		From: To:	$

Reason for adjustment: